

**EFFECTS ON SOCIAL WORK PRACTICE WHEN HEALTH SOCIAL WORKERS  
BECOME RECIPIENTS OF HEALTHCARE**

by

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## **Abstract**

For social workers, the continuous integration of learning from personal experiences is essential to professional growth and development. Increased knowledge and insight may occur through a process of critical reflexivity. Significant life events can be transformative to practice.

Healthcare social workers are often faced with the challenge of balancing competing interests and demands within a hierarchical system. Based on social constructivism and critical theory, this study used a cross-sectional exploratory design to examine how personal experiences of receiving healthcare services may affect the professional perspectives of healthcare social workers. Nine health social workers were interviewed following significant personal interactions with the health system. Findings spoke to the participants' perspectives on agency, alliance, critical reflection, and transformation arising from their experiences as healthcare recipients. All participants described altered perceptions of the health system and care recipients, and expressed renewed commitments to core social work values and activities. Implications for social work practice, policy, and research are discussed.

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I would also like to express my appreciation to the Fraser Health Social Workers who so generously shared their time and knowledge. This project would not have been possible without their full and insightful reflections. Their unwavering dedication to enacting social work values in healthcare has been inspirational.

## **Dedication**

This paper is dedicated to my parents, Charles and Kathy, who have always demonstrated their commitments to community involvement and social justice. Their values led me to social work.

It is also dedicated to my husband, Shawn, for his unfailing love and support. I could not have done this without him. And finally, it is dedicated to my son, Graeme, who has taught me the most about what is important in life.

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## **Introduction**

Social work is an insight oriented profession. Without question, social workers need to be attentive to the influence of their own values and beliefs upon their work. Moreover, the continuous integration of learning from personal experiences is essential to professional growth and development. Such self-awareness typically arises through an on-going process of critical self-reflection (Butler, Ford & Tregaskis, 2007; Fook, 1999; Heron, 2005; Huntington, 1998; Kumsa, 2011; Massaquoi, 2011; Morley, 2008; Smith, Chambers, & Bratini, 2009; Suarez, Newman & Reed, 2008). Particular life events may provide rich opportunities for increased knowledge and insight, especially where previously held beliefs, assumptions and expectations are challenged. “These moments can either stall or halt the learning process, or alternatively provide the opportunity for intense, vivid learning, pushing practice knowledge to a new, critical and important level” (Massaquoi, 2011, p. 218). While such experiences are often emotionally and intellectually disruptive for the practitioner, they also contain profound possibilities for practice transformation (Bransford, 2011; Massaquoi, 2011; Savaya & Gardner, 2012).

Within healthcare settings, social workers attend to the psycho-emotional and social aspects of health by providing counselling, facilitation, navigation, and advocacy services. Ideally, social workers could play a critical role in improving outcomes for people facing health concerns by intervening not only individually, but also at a systemic level to reduce health inequities. Because the pursuit of social justice is a core value of social work, the professional code of ethics in Canada obliges social workers to “advocate for fair and equitable access to public services and benefits” (Canadian Association of Social Workers, 2005, p. 5). However, the social work profession and the health systems within which social workers are employed

often have dissimilar interests and priorities. The dominance of the biomedical perspective as well as the hierarchical nature of health service delivery can present particular challenges for social work practice in health settings. As well, in keeping with the current political climate, healthcare organizations are increasingly focused on rationing access to services in order to meet fiscal constraints. This, in turn, intensifies the expectations placed upon individuals and families to manage a growing range and complexity of health and social care needs on their own. Determining how best to intervene under such circumstances requires social workers in healthcare to continuously apply critical thinking skills and make sound professional judgements, guided by a strong commitment to social work values and principles. For social workers, the development of core values and, further, the impetus to take actions consistent with those ideals is conceivably influenced in large part by lived experiences.

The purpose of this study is to explore how personal experiences of receiving healthcare services may affect the professional perspectives of healthcare social workers. Specifically, the objective is to examine how interactions as recipients of health services influence social workers' attitudes, expectations, or beliefs about the healthcare system, the social work role in health, and the experiences of people receiving care. The study explores whether having personal experiences of receiving healthcare services prompts critical self-reflection regarding one's own actions as a social worker, or influences subsequent social worker interactions or practice priorities towards people receiving care, their families or the healthcare team.

This study may inform priorities for on-going social work education and professional support, for instance selecting clinical strategies which enhance awareness of self in relation to individuals receiving healthcare. Such contributions to the continuing professional growth and development of social workers could improve overall social work functioning in health settings,

as well as the quality of healthcare recipient experiences. A better understanding of the factors which influence social workers' choice of interventions may provide a basis for future outcome studies to measure the effectiveness of professional responses in various specific circumstances in healthcare.

## **Literature Review**

The integration of the identity or sense of self of the practitioner into their practice is crucial to successfully fulfilling the social work role (Heron, 2005). On-going personal and professional self-reflection is therefore an essential element of social work education and practice development (Fook, 1999; Heron, 2005; Huntington, 1998; Kumsa, 2011; Massaquoi, 2011; Smith, Chambers, & Bratini, 2009; Suarez, Newman & Reed, 2008). The contexts that social workers practice in may either foster or limit opportunities for reflective practice (Mizrahi & Berger, 2005). In the absence of critical reflexivity, it is possible for social workers to unwittingly participate in the perpetuation of oppressive social structures. Therefore, critical reflection is in itself one form of social activism and resistance, creating new possibilities for critical practice and socially just responses (Morley, 2008). There is potential for liberation and transformation for both service users and service providers through the process of critical reflexivity.

## **Current Healthcare Climate**

The Canadian healthcare system is often described as being in crisis, citing problems with access, quality and affordability (Romanow, 2002). The neoliberal agenda seeks to reduce public spending on healthcare, favouring the wants of the marketplace over the needs of citizens

(Bransford, 2011). Public services are no longer seen as a social investment or right, rather “social work’s clients have mutated into customers and as such are themselves responsible for the causes of their difficulties, but above all, for the solution of their problems and with that their success or failure” (Stark, 2010, p. 15). In keeping with the biomedical model, health issues are typically framed as individual problems or deficits rather than indicative of broader social determinants of health. Despite political arguments to the contrary, “the ability to finance the welfare state is not a question of inadequate resources but of political will and distribution” (Stark, 2010, p. 13). Nonetheless, the common refrain in healthcare is that there is no more money for public services to respond to the health needs of the population.

Given the political climate and public funding limitations, health organizations often place a greater emphasis on fiscal accountability than clinical measures of quality (Webster, 2010). Managerialist approaches, which limit goals of intervention to rapid discharge planning and favour standardized completion of tasks, contribute to the de-skilling of social workers and hinder the development of effective therapeutic relationships (Bay & Macfarlane, 2011; Reisch, 2012; Webster 2010). The sheer volume of caseload demands may impinge upon the ability of social workers to pursue professional goals and objectives, including challenging unjust structures (Foster, 2013; Mizrahi & Berger, 2005; Webster 2010).

For social workers employed within the health system, there is continuous pressure “to meet consumer needs while balancing the profession’s ethic of empowering service delivery against new public management’s demand for ‘efficiency, economy and effectiveness’” (Webster, 2010, p. 28). Inasmuch as social workers are accountable to professional standards of practice and a code of ethics, there is no denying that social workers must be seen as contributing to the strategic imperatives of health organizations if continued employment is desired (Mizrahi

& Berger, 2005). Social workers must therefore exercise considerable discretion in their clinical interventions by weighing the mission of social change against the required functions of the practice setting (Salas, Sen, & Segal, 2010).

### **Position and Power**

Although not always well recognized by social workers, the professional role is a powerful one (Sakamoto & Pitner, 2005). How social workers choose to exercise their professional power is undoubtedly influenced by personal interests and biases. Although social workers prefer to emphasize more desirable occupations such as empowerment and advocacy, the profession has frequently exercised a role in social control as efforts are directed towards changing individuals to comply with societal expectations (Bransford, 2011). Social positions are not singular or fixed, but complex and fluid, thus requiring on-going exploration of who the social worker is in relation to specific clients and contexts of practice (Kumsa, 2011; Wehbi, 2011). Relative social position must be examined, with the acknowledgement that “social workers inevitably bring more power to their interactions with service users than vice versa” (Sakamoto & Pitner, 2005, p. 438). While it may be relatively easy to recognize the marginalization of other people, it is much more difficult to identify and admit one’s own privilege and participation in oppressive social processes or to take actions to disrupt them (Baines, 2011; Gulbrandsen & Walsh, 2012; Heron, 2005; Kumsa, 2011).

In examining issues of power and oppression, it becomes clear that oppressive relations are multi-faceted and often concealed. While oppression can arise from deliberate discrimination and contrived systemic constraints, it is also a product of the everyday actions of people who are possibly very well-intentioned and do not see themselves as “agents of

oppression” (Young, 1990, p. 42). While most social workers espouse the core value of social justice and attest to the importance of anti-oppressive practices, there is often a tendency to avoid acknowledging the oppressive experiences of themselves and others, and to deny personal participation in oppression (Gulbrandsen & Walsh, 2012; Heron, 2005; Huntington, 1998; Sakamoto & Pitner, 2005; Smith, Chambers & Bratini, 2009). For example, social workers may participate in oppressive activities out of loyalty to an organization, conformity with colleagues, self-protection in light of unequal power positions, underlying or unspoken values and beliefs, or feelings of uncertainty and helplessness (Savaya & Gardner, 2012). Further, the conception social workers have of themselves as committed to opposing discrimination or domination can make it difficult to examine personal imperfections or discrepancies between professional philosophy and practice (Heron, 2005; Sakamoto & Pitner, 2005). Often, awareness of power and privilege is raised only when an event occurs which causes professional and personal worlds to collide in such a way as to inescapably shift perspective.

### **Critical Reflexivity**

Critical reflection “is one way of maintaining mindfulness about practice and how practice fits, in specific instances, with social work’s emancipatory intent” (Bay & Macfarlane, 2011, p. 755). Critical reflection seeks to uncover underlying values and assumptions, make linkages between personal and collective interests, examine power relations, and increase the capacity for alternative actions and social change (Fook, 2003; Gulbrandsen & Walsh, 2012; Jensen-Hart & Williams, 2010; Sakamoto & Pitner, 2005; Savaya & Gardner, 2012). This “involves the ability to locate oneself in a situation through the recognition of how actions and interpretation, social and cultural background and personal history, emotional aspects of experience, and personally held assumptions influence the situation” (Fook, 1999, p. 199).

Critical reflexivity advances self-awareness and knowledge about the construction of each of one's multiple identities and locations within the social order.

In the absence of critical reflection, social workers are often not aware of or accountable for the discrepancy between espoused theories and actual practice behaviours (Savaya & Gardner, 2012).

Thus, critical consciousness challenges social workers to question how the dominant ideology has shaped their perspectives about their professional roles. Also, it challenges social workers to examine how the taking up of the authority within their professional roles may be perpetuating prevailing authoritarian power differentials, despite overt efforts to avoid doing so. (Bransford, 2011, p. 935)

Critical reflexivity and work toward critical consciousness is an “endless process” in quest of effectively using one's privilege as an ally to challenge oppression (Sakamoto & Pitner, 2005, p. 448). Ultimately, “the goal of critical practice is to assist individuals in seeing their oppression so they might engage in collective action that transforms society” (Salas, Sen & Segal, 2010, p. 94). For social workers, this means not only recognizing oppression, but acknowledging personal privilege and unintentional participation in oppressive structures and practices. Critical reflexivity, however, is only the beginning.

## **Transformation**

It is pointless to intellectually understand the dynamics of oppression unless this awareness is meaningfully incorporated into everyday practices (Bransford, 2011; Gulbrandsen & Walsh, 2012). Sustained action is the key indicator of transformation. A critical incident, or transformative disruption, can potentially be a turning point in practice (Kumsa, 2011; Savaya & Gardner, 2012). Such an incident is significant for the person involved, and often initiates a strong emotional reaction, resulting in feelings of anxiety, fear, sadness, shame, anger,

helplessness or inadequacy (Bay & Macfarlane, 2011; Bransford, 2011; Gulbrandsen & Walsh, 2012; Savaya & Gardner, 2012). This emotional discomfort is an important aspect of transformation, as it signals to the social worker “that there is more work to be done in order to be anti-oppressive” (Sakamoto & Pitner, 2005, p. 439). The ability to tolerate and work through the discomfort, rather than ignoring or avoiding it, is a precursor to change. If a disruption is truly transformative, the person never sees their work, or the world, in quite the same way again. Acknowledging our multiple subject positions and recognizing when we become the “other” allows us to develop profound empathy (Kumsa, 2011) and to become an ally for change in solidarity with others (Sakamoto & Pitner, 2005).

### **Gaps in Literature**

While there is wealth of social work literature regarding critical reflexivity and anti-oppressive practice, none is specific to the healthcare setting despite the obvious issues of unequal power relations and the vulnerability of people who require care. Most often, critical reflexivity has been discussed in terms of preparing social work students for practice (Bay & Macfarlane, 2011; Bransford, 2011; Jensen-Hart & Williams, 2010; Thompson & West, 2013). Although it has been acknowledged that critical reflexivity is ideally a never-ending process (Bay & Macfarlane, 2011) there is a lack of literature as to how critical reflexivity is fostered amongst already practicing social workers. This study provides insight into some of the processes and events which may contribute to social work professional growth and development, particularly in the area of anti-oppressive practice.



## **Theoretical Framework**

My interest in this research topic has arisen from my own experiences of being a healthcare social worker and subsequently becoming a “client” of various health and social services through my child’s diagnosis of autism. This has deeply informed my own social work practice, in terms of the social and emotional impacts of being faced with having to manage a chronic health condition, as well as the complexities and challenges of interacting with various service delivery systems. Perhaps most importantly, it has caused me to question the values and meanings commonly assigned to concepts such as “illness” and “disability”, including the social controls associated with such labels. Although neither anticipated nor desired, for me this experience has instigated invaluable growth both personally and professionally. While I am in many ways grateful for the perspectives I have gained through this experience, there are certainly times I have wondered whether similar insights could have been acquired less arduously. This has led to my curiosity about what other social workers learn from becoming recipients of care, including how such personal experiences contribute to the development of practice wisdom and/or commitment to social action.

Social constructivism proposes that common knowledge is created within social interactions, as one incorporates or generates meanings about individual and collective experiences. This approach theorizes that social responses are based on a continuous construction of reality, since the world can only ever be understood through one’s own subjective experiences of it (Anderson-Nathe, Gringeri & Wahab, 2013; Bourgeault, 2010; Bundy-Faziolo, Quijano & Bubar, 2013). In a sense, what actually occurs is less important than the stories people create for themselves about life experiences and events. Within a social constructivist approach, it would be expected that the “realities” of the health system would be

different, though equally valid, from the perspective of a healthcare provider as compared to a healthcare recipient. Social constructivists would argue that gaining a dual perspective, as both a social worker and as a client, would inevitably alter one's understanding of and subsequent interactions with the health system.

Critical theory attends to issues of power within social systems. Interpretations are filtered by social position and degree of privilege (Anderson-Nathe, Gringeri & Wahab, 2013). Critical theory places a strong emphasis upon raising awareness of personal biases, questioning social norms and examining how the distribution of power affects the conditions of particular individuals or groups in society (Salas, Sen & Segal, 2010). Critical self-reflection is key to consciousness-raising about our own roles in perpetuating the domination of current structures, which in turn drives action. Through the process of critical reflexivity, "once we gain an understanding of the social order, critical theory stresses that the knowledge we have gained will lead to social change and emancipation for those who are oppressed" (Salas, Sen & Segal, 2010, p. 92). According to critical theory, becoming a healthcare recipient could raise the awareness of social workers regarding client experiences within the health system, causing social workers to take actions to alter their own behaviours and challenge organizational structures and practices towards a greater degree of social justice in the delivery of health services.

### **Design and Methodology**

This study uses a cross-sectional exploratory design with individual semi-structured interviews to gather qualitative data (Dudley, 2011). This design was chosen because currently there is little known about the topic of critical reflexivity amongst practicing health social workers. It is also unknown which or what proportion of social workers currently employed in

health may have had personally significant experiences of receiving healthcare services. For these reasons, it was important to select a design which would be flexible and allow for in-depth data collection from a relatively small number of participants.

## **Recruitment**

Recruitment was initiated once approval had been obtained from the Research Ethics Boards of both the Fraser Health Authority on February 27, 2013 (Appendix A) and the University of the Fraser Valley on March 5, 2013 (Appendix B). As the researcher was an employee of Fraser Health, the Fraser Health Research Ethics Board application required confirmation from an administrative supervisor (Sheri van Lochem) that the principal investigator had the qualifications, experience, and resources to carry out the research study. Aside from approving the research project and circulating the invitation to participate, Fraser Health resources were not utilized to conduct this study.

A purposive sampling method (Dudley, 2011) was used to recruit individuals currently working as social workers in health and also self-identifying as having had significant experiences of receiving healthcare services. The sampling frame consisted of approximately five hundred social workers employed throughout various Fraser Health sites and programmes (including full-time, part-time and casual staff). Of these, it is unknown how many may also have had interactions with the health system as healthcare recipients.

Social workers were invited to participate in the study via an email sent on March 7, 2013 to all Fraser Health social workers by the Fraser Health Regional Social Work Practice Leader (Esther Krahn), explaining the study and its criteria (Appendix C). Potential participants were asked to contact the principal investigator to schedule an individual interview, at a time and

location of their choosing. Fifteen people responded to the invitation. One subsequently declined to participate. Two were excluded due to an employment-related reporting relationship to the principal investigator. Three people offered to participate, but either did not meet the criteria for having had healthcare interactions since becoming a social worker in health, or did not follow through with scheduling an interview. Between March and October, 2013, nine people provided written consent (Appendix D) and each completed a single, individual interview.

### **Operational Definitions**

For the purpose of this study, a health social worker is defined as someone who has completed either a Bachelor or Master of Social Work degree (BSW or MSW) and who is currently employed by Fraser Health to provide social work services. Receiving healthcare includes treatment or services related to an unexpected health event or the management of an ongoing health condition. The nature of the health event or condition was not specified as a criterion; social workers were invited to participate if they considered themselves to have had a “significant” interaction with the healthcare system as a client (as opposed to receiving routine healthcare). The social worker could either have received the health services directly, or have been a family member of an individual who received healthcare. The interactions with the health system as care recipients took place after the social workers had already been employed in healthcare settings, and the social workers had continued to practice in healthcare subsequent to their client experiences.

## **Data Collection and Analysis**

Face-to-face interviews were conducted using a semi-structured interview guide (Appendix E) with open-ended questions to gather qualitative data. Interviews ranged in duration from forty-five minutes to two hours and twenty minutes, with the average length of interview being one hour and fifteen minutes. Seven of the interviews took place at Fraser Health work sites; two were conducted at the participants' homes. All interviews were audio-recorded and hand written notes were taken throughout each interview.

Basic demographic data was gathered at the outset of each interview to enable a description of the sample of participants. Through open-ended interview questions, the participants were asked to discuss their own experiences of receiving healthcare services (either personally or in relation to a family member) and how this had influenced their own practice perspectives. Specifically, participants were asked to discuss what they had learned about the healthcare system from their client experiences and how these experiences influenced the way they felt about working in the health system. They were also asked how they thought being a health social worker affected their experience of being a healthcare recipient and whether anything had changed in their thinking about the role of social workers in health. Participants were requested to explain what they had taken away from the experience in terms of recommendations they would share with other clients needing to access healthcare or with colleagues delivering healthcare services. Participants were asked to reflect upon the influences of power within the health system and the application of anti-oppressive approaches in health practice. Most importantly, participants were asked what they had incorporated into their own social work practice since having the experience of being a recipient of care.

Following each interview, notes were made of key points and impressions which arose from the discussion. A transcript of each interview was then generated from the written interview notes and audio-recordings. Each transcript was reviewed in its entirety to identify major concepts. As well, the responses to each question were compared between all nine of the transcripts. This led to the identification of common themes. The themes generated were not closely associated with particular questions, but rather arose repeatedly throughout the interviews. Each transcript was then reviewed again to particularly highlight where participants had spoken about changes to their practice as social workers since their experience of receiving healthcare services.

### **Ethical Considerations**

The researcher was employed in a social work leadership position within Fraser Health therefore it was important to consider the implications of involving Fraser Health social workers in this research study. Some social workers may have perceived that a decision whether or not to participate in the study would affect aspects of their employment (either positively or negatively) due to the power associated with the leadership position. As well, some social workers may have been concerned that private information about personal health conditions would be revealed and have subsequent employment impacts. For these reasons, no person with a reporting relationship to the researcher was permitted to participate in this study. However, it is possible that a reporting relationship could subsequently occur or there could be interactions with any of the participants, in future, in the course of employment related activities. Therefore, the confidentiality of the research was reviewed with each participant and consent was obtained prior to initiating any interviews. As all participants were working in Fraser Health as social workers at the time of the study, the capability to provide informed consent was presumed.

Personal health related events can have significant emotional impacts. In both the recruitment letter and the informed consent form, participants were asked to consider whether they were prepared to discuss their experiences of receiving healthcare, taking into consideration how recently this had occurred and how personally impactful the experiences had been. All participants were advised that they could decline to respond to any questions and could stop the interview at any time. They were also reminded of the availability of follow-up counselling services, at no cost to Fraser Health employees, via the Employee and Family Assistance Program. For some participants, discussing this topic did bring up significant emotions. Not surprisingly, it was more emotional for people to discuss health events which had been sudden or life threatening (for themselves or for their family member), and where there was a perception that the outcome could or should have been different based on the care received. Depending on the nature of the interaction with the healthcare system, some participants were more emotionally vulnerable than others when reflecting upon these events. The experiences shared by some of the participants also raised emotions for me as I recalled my own experiences as a healthcare recipient. These feelings were acknowledged as they arose, and none prevented the continuation of the interviews.

Some of the comments made by participants were critical of healthcare services, including the actions of certain professionals and the delivery of services within Fraser Health. As the findings will be discussed within Fraser Health and it will be clear that all participants were Fraser Health social workers, this could have some impacts on the general perception of social workers by other professionals within the organization.

## **Limitations of the Study**

The research involved nine participants, all of whom were employed as social workers in Fraser Health and self-identified as having had significant interactions with the healthcare system as clients. In many respects, the majority of participants were comparable in terms of work experience and social location such as age, gender, and ethnicity. As the researcher, I am very similar to the predominant participant profile, as a Caucasian woman in my forties with seventeen years of social work experience in Fraser Health and who has had an experience of receiving health services in relation to a family member. It is possible, in my analysis, I may have over-identified with certain aspects of the participants' experiences to the exclusion of others. Reliability of the results may have been improved by involving a second reviewer in the theme analysis (Dudley, 2011).

The small size of the sample is a limitation. As well, it is probable that the sample of participants is not representative of Fraser Health social workers in general, but rather consisted of those who have greater interest in research (i.e., MSW prepared social workers) and the availability to devote time for an interview. For example, casual social workers (who tend to be younger and have less work experience) may have been less able to schedule an interview due to the unpredictability of work schedules. There was only one male in the sample, and only two people who identified as belonging to minority racial/ethnic groups. It is not possible to fully generalize the findings of this study to other health social workers.

Conducting the study within my own workplace and that of the participants was also a limitation. Some individuals who wished to participate and would have had valuable insights to contribute were excluded from the project due to their reporting relationship to the researcher. It



is possible that some other potential participants may have been reluctant to share information with a fellow Fraser Health employee with whom they could have future professional interactions.

Within this sample, four of the participants had personally received healthcare whereas the remainder spoke of experiences relating to family members. Within this group of participants, it appears that the personal experiences of receiving healthcare, especially with respect to a chronic or life threatening condition, was more impactful and tended to initiate a greater degree of practice reflection as compared to being the family member of a person receiving care. Distinguishing the nature of the client interaction with the healthcare system would be an important consideration for future research. As well, participants shared experiences which were predominantly related to physical health concerns for themselves or family members, although the invitation allowed for a broader interpretation of health events or conditions. Possibly stigma associated with mental health concerns deterred social workers with such experiences from volunteering for the study or disclosing these conditions, particularly because recruitment occurred in the workplace. It is likely that healthcare interactions related to physical conditions would be dissimilar to those for mental health conditions, and may have led to different experiences and reflections by social workers receiving care. Differentiating the type of health condition would also be an important consideration for future research.

## **Findings**

Amongst the nine participants, there were eight females and one male. Six had obtained an MSW, and three had a BSW (although two of these were enrolled in MSW programmes at the time of interview). Five worked in acute care hospital settings, and four worked in chronic care

and/or outpatient programs. Most worked full-time, although three worked part-time, including one who indicated she was working part-time specifically as a result of her health condition. The majority of participants (five) were aged in their forties, with one participant in her thirties, one in her fifties and two in their sixties. The participants averaged sixteen years of experience in health social work, ranging from seven years to twenty-nine years. Two participants identified themselves as belonging to visible minority groups. Another noted that her family members (by marriage) who received healthcare services belonged to a minority group, both racially and linguistically. One participant initially stated that she had no diversity factors which would be relevant, but later in the interview disclosed affiliation with a specific religious/cultural group which has historically faced persecution. The remainder of participants identified as Caucasian and disclosed no other diversity factors (i.e., race, language, ability, sexual orientation, etc.) for themselves or their family members.

Five shared experiences with respect to family members receiving healthcare, three had had significant health experiences themselves, and one person commented on both family and personal experiences. For reasons of privacy, participants were not directly asked about the nature of the health event or condition which precipitated their interactions with the health system. Nevertheless, in describing their experiences most of the participants disclosed sufficient details to ascertain that physical health conditions or events were the predominant source of their health interactions. Where mental health concerns were referenced, these were typically described as secondary to the physical health concern (for example, symptoms of anxiety and depression following diagnosis of a physical condition). Participants spoke about health interactions which occurred in primary care, acute care, outpatient services, home health, and residential care. Two participants shared health events which had been sudden and time-

limited; the remainder spoke about health conditions which were more ongoing or repetitive in nature.

In many respects, the experience of receiving healthcare was consciousness-raising for these health social workers. “Consciousness-raising, then, is recognizing that a given social practice is oppressive, and then deliberately working to change the practice. This is done by altering one’s social performance and disrupting the recursive process that maintains the oppressive practice” (Wheeler-Brooks, 2009, p. 123). Throughout the interviews, participants shared their observations of how the health system functions, recognized and articulated the resulting impacts upon themselves and other service recipients, and described how their perspectives as health social workers had been either affirmed or altered. Several participants described the experience as “eye opening”. For many, the experience had been disruptive to previously held beliefs and did contribute to practice change.

For all of the social workers interviewed, the experience of directly interacting with the health system as “clients” raised their awareness of the types of issues people and their families encounter when seeking healthcare, and also provided a deeper understanding of the psycho-emotional impacts of health events. As one participant remarked, “as a client, you become more aware of the cracks in the system” (Participant #7). The social workers commented on interactions with health professionals which they found to be particularly helpful or hurtful, and reflected upon the function of social workers in the health setting. Most of the social workers described changes to their own practice perspectives and/or approaches following the experience of being a healthcare recipient.

Four major themes arose from the data. Various factors were identified which either permitted or prevented access to and delivery of needed healthcare services. In some instances, the participants related this to characteristics of the individual client or social worker which either helped or hindered the ability to function within the health system. This theme is identified as “agency”. Agency refers to “the capacity of individuals to take action in order to make things happen” (Brown, 2011, p. 97) on their own behalf. In other instances, the participants associated access or barriers to healthcare with aspects of the interaction between service providers and recipients. This theme is identified as “alliance”. Alliance is the interpersonal or therapeutic bond through which service providers and clients work towards a shared purpose (Dumbrill, 2011). The tendency of participants to question themselves is associated with the theme of “critical reflection”. Critical reflection is the process by which one “examines implicit and hidden assumptions in order to change dominant and taken-for-granted thinking and arrangements” (Bay & Macfarlane, 2011, p. 746). The final theme of “transformation” refers to new knowledge, insights, and behaviours which participants identified as arising from their experience.

### **Agency**

From their experiences both as health social workers and healthcare recipients, including observations of their own colleagues and clients, the participants spoke about the different factors which they saw as contributing to active participation and achievement of results from the health system. Although associated with individual characteristics, agency for both care recipients and care providers was strongly influenced by background context. Healthcare recipients encounter the health system from a variety of family and social circumstances, articulated as the social determinants of health. For social workers, there is additionally the

framework of professional training and identity. Interactions with the inter-professional team are required of both healthcare recipients and healthcare providers. Agency reflects the ability to negotiate interactions with the healthcare team in such a way as to have one's needs and interests met.

**Personal agency.** Participants saw themselves as having an enhanced ability to function within the client role. As one participant put it, “knowledge really is power” (Participant #2). Many participants spoke to the vulnerability of people seeking healthcare. With respect to the client experience, “if you aren't able to stand your ground and just be persistent and be a voice for yourself, you will get easily lost and there'll be no one to pick you up” (Participant #5). The participants recognized that having knowledge of the healthcare system and being able to direct the process, at least to some extent, had significant impacts on their own outcomes. Having existing medical knowledge assisted them to know which questions to ask, as well as the ability to choose from a wider range of options. Knowing who to go to about particular issues, and in some instances having a pre-existing relationship with healthcare providers, was also a benefit. Several participants expressed the belief that they were able to attain services more quickly because of their insider knowledge and connections.

The participants actively sought out information about their own healthcare, for instance accessing and maintaining any documentation relating to their own health services or conducting research about treatment options. As clients or family members, they were willing to challenge other health professionals when there were disagreements about approach or to ensure follow-through occurred. In addition to communicating assertively when they were clients, the participants expected to have collaborative relationships with healthcare providers. For example, when one participant felt she was treated abruptly by a physician, she revealed her status as a

health professional “and he just took a step back after that and completely changed his attitude towards me. It was completely different, it was almost more of a peer respectfulness because I was in the hospital” (Participant #5). Based on position alone, the social worker was able to alter the interaction and command greater attention from the healthcare provider.

Although some social workers chose to use their professional status to their own benefit as clients, other struggled with this.

I just thought, you know, do I pull any strings here? Or do I just, you know, not pull strings because I don't want to get favouritism. I think I was very aware of that as a patient. Just, you know, do I try to use the system that I work in, or just be a regular person and not take advantage of that? (Participant # 7)

When health social workers encounter a strained healthcare system as clients, core social work values of equality and just allocation of resources can be challenged by a personal need to receive an adequate level of healthcare. Regardless of whether or not individuals chose take advantage of their professional status from within the client role, they were conscious of the privilege they possessed.

At the same time, being acknowledged as a professional was not always an advantage for health social workers. One participant perceived that her status as a social worker led her physician to have higher expectations of her ability to quickly integrate a new and serious diagnosis, as though they had been discussing the health condition of any other patient rather than something which personally impacted her and would require an adjustment process. There seemed to be an assumption by the physician that the social worker should have been able to handle her diagnosis better than an average patient by virtue of her professional training and experience. This participant commented particularly about how difficult it is to act on one's own behalf in the wake of an event with high emotional significance. Though this individual was

recognized by a colleague for her well-developed medical and health system knowledge, her emotional needs were simultaneously negated.

While for the most part recognizing their own privileged position as clients, the participants spoke extensively about the various vulnerabilities which create barriers to active client participation. These included social determinants of health such as age, ability, socio-economic status, culture, race, and language. “I know it’s harder if you don’t speak the language, if you can’t read or write or if you rely on other people” (Participant #3). One participant, who identified as belonging to an immigrant family, commented that there was a

...fear of accessing the healthcare and how you’re going to be treated. Whether me or my family members are actually going to get good care. And also just knowing that you are going to be treated with dignity and respect. I wouldn’t necessarily say that it’s a very satisfying experience and something that I really feel confident in, that I really trust (Participant #3).

Although other participants talked about feelings of anxiety, frustration, anger, isolation and discouragement, this was the only participant who specifically used the word “fear” in relation to interactions with health professionals. This may speak to the high level of exposure sensed by more vulnerable client groups relative to the power of health professionals. Other sources of client vulnerability included stigma and blame associated with disease labels, stress or strain in family relationships, limited access to support, misinformation or lack of knowledge about the health system, lack of communication, and a “blind trust” in health professionals. The urgency of time within the health system also creates vulnerability, as people are expected to make critical decisions almost immediately. Finally, a sense of defeat or inertia and having been rebuffed in previous help seeking efforts detracted from the capacity to engage with the health system on one’s own behalf. This was identified as a particular concern for clients with mental health conditions, not only because the condition itself may limit a person’s willingness and

capacity to seek help, but because such conditions are less “tangible” in the eyes of health providers and therefore the legitimacy of mental health disorders is often questioned.

The participants saw the role of health social workers as assisting clients to gain capacity in these areas. This included being a source of information, providing education or skills coaching, and being an ally or “point person” who could facilitate communication, generate options/choices, advocate, and assist to ensure the resolution of concerns by other healthcare professionals. The social workers believed they could help other members of the healthcare team to develop a broader perspective, “so we can bring to the healthcare system a kind of awareness and hopefully a responsiveness to the larger needs of these individuals. That’s the gift I think we bring to healthcare” (Participant #1). Even something as basic as interpretation and translation services could be arranged by social workers to enhance client agency.

The participants also spoke of the importance of validating clients’ experiences, promoting rights, and encouraging clients to be persistent or to seek out alternatives if their needs were not being met. One participant described how she encouraged people to approach the health system, as follows:

I’ll say, you’ve really got to push for it. You have to. You can’t give up. You have to just keep pushing and pushing and bug them. And it’s almost like once you bug them enough, I don’t know if they get tired of you or they just finally listen to what you’re saying. But a lot of families don’t have that ability. So often, we do it as social workers, in advocating for families. It’s the words you use and saying some of those catch-phrases to the family. “I would word it this way, because you might get quicker service”. And it actually works, unfortunately. It’s knowing how to, I don’t want to say manipulate the system. Just the knowledge of the system. I think that’s what it comes down to, is the knowledge of it. (Participant #5)

For anyone in the client role, participants noted the importance of actively pursuing a response from healthcare providers to overcome the risk of being overlooked or ignored.



Helping clients to process and resolve emotional content associated with a health event was seen as critical to preparing clients to effectively communicate needs and preferences in order to self-advocate within the health system. Participants spoke about how stressful the experience of managing health events had been for themselves, at times resulting in feelings of frustration, anger and fatigue. The stress itself contributed to a reduced ability to function effectively in relation to the health system. “I mean, you’re stressed out, there’s no way you absorb everything” (Participant #5). Clients were seen as particularly vulnerable at the beginning of their health encounter. “People need time to change and adapt. I’ve been through the experience of getting a diagnosis that bowls you over. My clients have that experience. It’s probably the low point of your life” (Participant #1). Participants believed that people become stronger and more able to demonstrate personal agency as they are able to process the emotional impacts of the health encounter and gain expertise as to what is effective when interacting with the health system. Unfortunately, the rapid pace of the healthcare system does not often afford clients and families this opportunity to adjust. Assisting with this adjustment process, including instilling hope at early stages of diagnosis and/or treatment, was identified as an intrinsic role of social work.

**Professional agency.** In addition to their reflections on the factors which contribute to agency amongst clients, the participants also identified components affecting their own capacity to take actions professionally. These included having a strong theoretical foundation, robust professional and systems knowledge, a sense of professional identity and autonomy, the ability to articulate professional priorities or utilize creative approaches, and having allies within inter-professional work teams.

I think that if we were able to be more confident and more clear about our own skills and training and education and have more ongoing training and skills in certain areas where we also feel more confident, then we can communicate that and give maybe more training to our interdisciplinary colleagues. (Participant #3)

Being secure in one's own skills and abilities, as well as having opportunities for continuing professional development, enhanced the function of social workers in the work environment.

Believing in the value of the social work role and having evidence of making a difference were also important to building a sense of professional agency. One participant spoke about how social workers contribute to the client experience, because "they know someone who's got the goods, that has some influence and knows the way" (Participant #9). In this way, social workers can relieve some of the anxiety experienced by clients and families in their health encounters. Furthermore, social workers can influence medical outcomes by pulling together all the pieces different health professionals contribute.

I asked for the social worker and things changed. And my mother's trajectory was much better than it was without the social worker involved. It wasn't until we got social work involved that we were able to say, to the doctor, where are we going with this? What's happening? (Participant #8)

Social workers saw themselves as sometimes being the most consistent person involved in a client's health journey, and having the capacity to move processes forward on their behalf.

As much as social workers strongly identified as client advocates, at the same time, participants saw themselves as having some degree of role conflict within the health system.

So, I think it's a delicate balance for us, to support clients and families through a system that's far from perfect. And supporting a system that is our employer and signs our paycheques. We need to find tactful ways to approach oppression within the system, within society. (Participant #9)

Participants spoke of the many competing demands on their time and commitments, and not always having the opportunity to address important emotional and family issues in light of

systems pressures to move people along. Participants did not feel that their skills as social workers were always appreciated or utilized to their full potential within the health system.

Barriers to professional agency were system constraints, fragmentation, role restriction, being directed by management or other health professions, lack of experience, training or confidence, workload, work setting (acute or chronic care), and lack of communication. One participant referred to having to recognize that she is a “cog in a big machine” (Participant #2), where organizational imperatives may bear no relation to professional priorities, and power can be limited. Similarly, another participant stated “we don’t have all that much power though. I think we can try to rally the forces but in fact we’re just part of the wheel” (Participant #7). Social workers spoke extensively about the changing climate of healthcare limiting their effectiveness.

People used to come into the hospital and we used to look at them as an individual and as a human being and as a person and understand them and align with them. We don’t do that anymore. We can’t do that anymore. And so I see that we’re losing the focus of the client, of the patient. We’re losing that, and they’re just becoming pieces of meat that we slice up. And we slice and dice and send home. We don’t have that caring component anymore. (Participant #8)

The shifting priorities within healthcare, primarily to meet system needs, are seen as oppressive to both clients and to social workers, affecting the quality of patient care as well as work satisfaction. Participants described no longer feeling good about the work they were doing, because of the high volume of demand and the inequities in service delivery.

Potential strategies to improve professional agency were identified as self-care on the part of health professionals, as well as system supports for employee wellness. “We have to be able to take care of ourselves and be aware of ourselves and when we’ve hit our wall” (Participant #5). Conflict resolution processes within the system were seen as important, to ensure that

different perspectives could be heard and concerns could be resolved effectively. Additionally, the opportunity to participate in and present research was suggested as a strategy to increase the confidence and profile of social workers in health, as well as respect for the social work role. Finally, it is important for social workers to re-evaluate their function in healthcare and avoid being caught up in systemic pressures which can ultimately defeat professional objectives.

So many of the younger social workers, maybe they're insecure in their practice, and they're very much in a hurry. Oh, sometimes I just want to give them a big hug and tell them to slow down. Really, really. If they don't slow down, they miss the strengths that the person brings, their own ability to generate solutions. (Participant #1)

Access to support to maintain professional identity and meet practice objectives, regardless of system imperatives, is crucial to professional agency. Professional agency, in turn, influences the quality of social work services received by clients and families, and parallels opportunities for clients to develop personal agency.

## **Alliance**

The level of alliance between healthcare providers and healthcare recipients depends upon the quality of inter-personal interactions and the extent to which there is agreement about the purpose and approach to care. A positive working alliance may help to overcome the sense of isolation and inertia which many of the participants described early in their health encounters, and increase agency of both parties. The participants provided many observations as to the factors which contribute to functional relationships between health professionals and healthcare clients. Having the time and commitment to develop relationships was seen as critical. This was noted as a particular strength of social workers, especially when it came to perceiving and presenting the whole person in their family context, as opposed to just attending to a disease or diagnosis. Client participation in developing alliance was also discussed.

The patient really has to contribute to the therapeutic relationship with the doctor. You can't go in there passively and expect your doctor to understand and make good decisions entirely on your behalf. You've got to go in there armed with questions and information. (Participant #1)

Beyond preparing for interactions, clients also need to consider aspects of relationship-building with healthcare providers. "You're receiving from them but you're giving back as well. Even if it's gratitude, good faith, or a tray of muffins" (Participant #9). For clients to feel heard and really cared for, but also for healthcare personnel to feel appreciated for their work, is foundational to functional exchanges. This may require a shift in perspective for both health providers and health recipients, to each see themselves and the other as contributing equally to the success of the therapeutic relationship. It again raises the question of how healthcare recipients gain capacity or sufficient power to interact with health professionals as equals.

The participants working in chronic care settings observed that there was the opportunity to build relationship with clients and families over time. The chronic care social workers expressed concern for the capacity of their social work colleagues in acute care to develop similar therapeutic relationships, simply because of the brevity of client and family interactions in that setting. Several of the participants had purposely chosen to work in chronic care programs, perceiving prospects for more in-depth involvement with clients and increased potential for making a positive difference. Functional inter-personal relationships between professionals and clients allowed for necessary interventions to occur with respect to more sensitive topics, such as death and dying, or sexual health. It was seen as important for clients and families to have a primary, trusted person to go to with any questions or concerns. One participant talked about care providers and care recipients being able to recognize one another as individuals beyond the healthcare interaction, commenting "it's interesting how the relationship kind of turns when they become that real person" (Participant #5). This speaks to the impact of

developing caring human connections, beyond the functional tasks to be accomplished in health service delivery.

The participants viewed healthcare delivery ideally as a collaborative partnership between health providers and healthcare recipients. For this to occur, mutual respect and a strengths focus were seen as necessary. This included accepting one another's expertise (both as a professional and as a client) and being receptive to the perceptions, experiences, and choices of the other. As well, the health professional must take the initiative to sensitively explain health conditions and rationale for treatment recommendations, while being open to questions and feedback. Because clients may not have experience with healthcare, the participants felt it was important for healthcare providers to initiate such conversations, anticipate gaps in client knowledge, and actively verify client understanding. The participants recognized that the health system may not be able to meet all client wants and needs, and believed that transparency was an important aspect of alliance, in terms of acknowledging system deficits and errors. As well, they felt it was important to be clear about commitments and to manage client expectations by frankly explaining what could or could not be done in particular situations. The participants also noted the importance of considering and attending to quality of life of healthcare recipients, including social, emotional and spiritual aspects, beyond simply providing physical care.

Interestingly, all of the participants spoke of their client experiences as affirming the importance of the role of social work in healthcare, yet very few of them encountered social workers during their experience of receiving health services. Some spoke to friends and colleagues who were social workers or to other helping professionals (such as counsellors). Only one participant had repeated contact with social workers as a client; others who met with social workers did so only briefly, typically when they had specifically sought out the social

worker. Nevertheless, participants for the most part spoke highly of the interactions with social workers which did occur.

I think as a consumer or receiver of healthcare, I was completely oblivious to the social work workload or what they were doing on what else they were involved in. I just knew during the half a dozen brief encounters I had with the different social workers, they were very present during that time. They were very supportive, compassionate, informative, validating, resourceful, I mean, all of these things. And they just seemed to arrive when, you know, when I needed them. They showed up at opportune times, somehow. I don't know how they did that. I knew some of the nursing staff and I knew other physicians and others involved too. But the only ones I have memory of now, looking back thirteen months after the fact, were the social workers. (Participant #9)

This speaks to the skill social workers have in developing meaningful alliances with clients.

Again, this takes some time and commitment on the part of social workers, "because the best work gets done when you stop, breathe, and you hear their story. Really hear somebody's story" (Participant #8). Such presence on the part of social workers is foundational to therapeutic alliance.

**Barriers to alliance.** The participants identified a number of barriers to alliance. For instance, a delay in the ability to access needed services blocked alliance. Because participants were not able to access services within the health system in a timely way, some of them looked for alternatives such as naturopathic remedies. This reduced alliance to professionals in the health system, in part because of the sometimes contemptuous attitude by mainstream healthcare providers towards such approaches. Lack of time and busyness were seen as factors contributing to superficial interactions and a tendency to brush people aside or see the client concerns as "not my job". However, as one participant put it, "as healthcare providers, we go 'I'm too busy', but what we forget is, we wouldn't have our jobs if it wasn't for those people standing in front of us" (Participant #2). It is important, therefore, to re-focus on the purpose of healthcare and who is being served.

At the most basic level, healthcare providers may fail to engage effectively with care recipients or accurately assess level of client knowledge. “I think that healthcare workers make assumptions as to how much or how little information patients and families have, and need” (Participant #9). Some participants described feeling largely ignored by health professionals during their healthcare encounters. At the same time, clients expressing overt distrust of health professionals can also be a barrier to alliance. For example;

Anticipating an adversarial relationship, I think that’s a recipe for a bad ride. I would urge people not to be passive, a passive participant throwing themselves at the mercy of the system. But I would also urge them not to go in there with, you know, a full barrel advocate in tow ready to do battle with the healthcare system. I mean, I don’t think that’s the way to get off to a good start. (Participant #9)

Once labelled by the healthcare team as overly assertive or aggressive, clients and families may have very limited opportunity to develop beneficial relationships with health providers in future.

When healthcare providers deliver information, there is typically an absence of discussion with clients and families about how such information is being received, especially with regard to emotional impacts. In sharing an experience of talking to a physician about discontinuing life supports for a close family member, the participant noted that it was “very factual”.

It was done with sensitivity, but I don’t recall the physician ever asking me, you know, how are you with this? How is this impacting you? And do you have supports? I don’t remember anyone but the social worker asking those sorts of questions. (Participant # 9)

It is important to note, again, that very few of the participants had any interaction with social workers in the course of their client experience, and often found themselves called upon to function as “surrogate social workers” (Participant #9) for the rest of their families while in the client role. As clients, social workers were often expected to continue to function as professionals, and were not seen as requiring the services of a social worker themselves. Despite



the potential boundary issues, for some participants there was a degree of comfort in retaining a more professional role, perhaps because of the status or sense of control this afforded as compared to the client position.

There is often a narrow focus of healthcare, such that health conditions are seen as discrete physical problems, with no bearing on the person, their family or their broader lives. Many participants noted the extensive impact of the health event upon their families, which the healthcare system did not acknowledge or address. At times, participants found healthcare providers overtly dismissive of the impacts of their health conditions. For example, one participant was discussing her diagnosis with a nurse who commented “oh, that’s an easy cancer to cure”. For the participant;

It’s got nothing to do with the kind of cancer I had - it’s the fact you have to go through this same ordeal. You have to go through the surgery, you have to go through the radiation, you have to go through the chemo or whatever. You feel like you are not being acknowledged for what you’re going through. Like the feelings and emotions. So I think sometimes the healthcare system unfortunately takes the feelings and emotions out of it. I think that’s why social workers are so needed in the hospital setting. And I think we need more, because doctors just don’t go there, they don’t go to the feeling and emotions. (Participant #5)

At the same time, this participant speculated that this disengagement from the experiences of healthcare recipients may be a survival mechanism on the part of health professionals, who have been “taught to save” but aren’t always able to. In other examples, it seems that health providers limited to their efforts to the identified “client” and it simply did not occur to them that the rest of the family might also require care as a result of the health event. This likely reflects the medical model, rather than a systems perspective, remaining as the dominant approach within healthcare.

The most notable barriers to alliance are hierarchical relationships, the misuse of power, and a focus on the system rather than the client. “It’s a bureaucratic system and when you’re the person at the bottom of the hierarchy, it’s very challenging” (Participant #5). One participant provided an example of a doctor who refused to continue to follow a patient unless she was compliant to his orders and another referred to the potential of being “fired” by a doctor because of being too assertive. Yet another participant shared an example of a disagreement between a family member and a doctor about the direction of care. “In the end he said, well, that’s why they call me an MD. My Decision” (Participant #7). Participants routinely observed (as professionals) or experienced (as clients) being shut down in attempts to question physicians’ rationale for treatment recommendations, which was presumably seen by doctors as challenging their expertise.

Although most examples of use of power involved interactions with physicians, one participant acknowledged the pervasiveness of power dynamics in any professional relationship and the ameliorating actions social workers could take.

I think we’re pivotal and we can do either. We can reinforce disempowerment, for those that feel really disempowered already, or already feel really at the mercy of the system. We can reinforce that. That “yes indeed, you are powerless and we have all the power”. On the other hand, you can help people begin or perhaps continue to rewrite, retell their story, retell their narrative, right? And perceive the whole situation in a different way and come away from the situation feeling more empowered, more informed, more aware, more responsible for their own health, well-being. But I think all of this also comes through, I mean it all happens in the context of the relationship. (Participant #9)

Addressing issues of power in relationships in health settings first requires recognition that social workers are often bystanders, and potentially active participants, in the power dynamics within teams and directed towards clients.

## Critical Reflection

The experience of receiving healthcare prompted participants to think about the client experience differently and begin to question their own approaches to providing care. As one participant put it, “it was interesting walking in and seeing my mother-in-law in a geri-chair and going – Ew, ew! That’s not right. She’s a pain, so they’ve stuck her in a geri-chair. Oh, so this is how that feels” (Participant #4). This allowed her to consider the use of power within the system and the impact this has on clients and families. This participant also talked about her feelings of embarrassment when she encountered certain circumstances as a client, and in retrospect realized how she had previously described such situations to others from her perspective as a social worker.

All of the social workers talked about how much more difficult it was to interact with the health system as clients than they had previously realized. In talking about all of the efforts she had to make to ensure her family was able to access the services they required, one participant commented, “but at least I knew. Like the thing is, I keep thinking – what would have happened if I hadn’t been around” (Participant #4)? Similarly, another participant noted;

If I was a person who didn’t know a healthcare system, how would you get the support? Because if I didn’t know what I know because I work in this system, how would somebody who doesn’t know the system guide themselves through it? (Participant #6)

In general, the participants became much more attuned to the challenges and complexities of the health system through their encounters as health recipients, and began to question how an average client could possibly manage these. The single participant who felt he probably could have successfully negotiated the healthcare system without his pre-existing level of insider knowledge credited his privileged position as a white male as a contributing factor. The

experience of receiving health services compelled participants to think about barriers and challenges encountered by clients, and to reconsider the importance of their own contributions as social workers in terms of assisting clients to navigate complex systems.

In particular, the participants reflected upon the competing interests of the healthcare organization and their own profession, as well as the utility of different actions individuals may take to resolve such conflicts. Referring to a colleague who had adopted a deliberate strategy of focusing her practice exclusively upon procuring discharge resources;

With a healthcare system like ours, people that can practice like that are kind of valued. So, I don't know how much difference that made to her clients, but I saw what a good fit she was within the healthcare system as it is designed now. That's a troubling thing.  
(Participant #1)

This participant described her colleague as very popular, in large part because she was so efficient in managing the caseload and clearing referrals. At the same time, this led the participant to wonder whether her colleague's attention to system priorities was overriding her professional obligations to clients, such as assessing and responding to client needs and preferences.

Following their own experiences of receiving care, many of the participants began to question their priorities as social workers. "Who do I prioritize? Who do I look at first? Why am I here? Can we meet organizational priorities as well as our own social work values?" (Participant #2). Participants became more concerned about the impacts of their efforts, asking "How am I making a difference here? What power do I actually have? (Participant #3), and considering "Whose needs are being met? Is it the client's? Is it mine? Or is it the system's? Or anybody's?" (Participant #9). Through the experience of being clients, participants were

prompted to ask themselves questions to evaluate their own practice as social workers, and to consider how they measured up to organizational, professional, and client expectations.

Even where it could be argued that systemic priorities were somewhat consistent with core social work values, such as self-determination, participants question their own participation in the approaches and actions taken by health organizations and whether these are now pushing beyond acceptable limits.

Well, there's always a lot of pressure as a social worker. Pressure to get people out and you know how marginally they might be living and at risk and we're part of that. But, you know, people have a right to live as risk. It's just sometimes you wonder where is the safety? Where is the safety net? And how much risk are we wanting people to have? (Participant # 7)

Some participants felt that they had limited influence on discharge decisions, since the discharge order is a physician function. Others sensed a responsibility to “fight” discharges which they believed to be unsafe, despite describing such efforts as often exhausting and ineffectual. It is possible that risk- awareness and risk-tolerance may vary between different health fields, or even within a profession such as social work, which likely contributes to differing levels of comfort with various discharge arrangements. Since social workers are oriented towards the person-in-environment, much more so than other health professionals, it is predictable that social work would be the discipline most likely to raise issues of risk in community functioning. This is an important issue for social workers to continue to identify and contemplate, both within the profession and for the benefit of inter-professional teams.

The participants also noted the importance of being aware of their own boundaries in relation to the client experience, or to “be mindful of what’s mine and what’s theirs” (Participant #6). Although they related to clients differently following their own experiences of receiving healthcare, participants reflected upon the danger of over-identifying with clients, and thought

about how much of their client experience it was appropriate to bring into their professional interactions. Participants spoke about not wanting to make assumptions, to impose their own experiences upon clients, or to take over in terms of advocacy or determining the direction of care.

Some of the participants also reflected on how the healthcare experience had changed them. “Who was I during that process, and how did I evolve during that process? And who am I now that that process is complete. Or is it complete? What have I brought with me?” (Participant #9). Some made comments questioning the application and meaning of labels arising from their experience as a healthcare recipient.

I think what makes me emotional about this is I like to think of myself as healthy and I am basically healthy, but the fact is that technically I’ve had two [major health events] and that just makes me think, oh gee, if I heard that about somebody else, I’d think – hmmm. (Participant # 7)

Through reflection, this participant was beginning to realize that she had become the “other”. She was now questioning both the conclusions people might be drawing about her situation, which would not fit for her, as well as the judgements she had imposed on others in similar circumstances.

## **Transformation**

The final theme of “transformation” refers to new knowledge, insights, and behaviours which participants identified as arising from their experiences of receiving healthcare. All of the participants articulated the extent to which their experience as service recipients had helped them in their work and given them much greater empathy towards clients and families, truly recognizing the challenges people face in their health system encounters.

But I would say my experience of illness has really deepened my understanding, my compassion. I can so understand now how people get discouraged with treatment. Medication side effects are sometimes dreadful and yet you are treated as a “less than” person if you complain or you stop taking your meds. It’s given me a lot deeper understanding of why people make the decisions they do. (Participant #1)

Although the participants described varying degrees of impact resulting from their experiences as healthcare recipients, all noted differences in their perspective since these events. For some, the change following the client experience was profound, both professionally and personally. One participant went so far as to say “so that changes everything that I do with my clients, and who I am” (Participant #6).

As a result of this increased empathy and shift in perspective, social workers were able to connect with clients differently and build stronger alliances.

You have a deeper awareness of the emotions of everybody involved. And so it takes you to a different level of understanding with the family and with the patient, without them knowing. It just takes you to a very deep level with them. And you don’t say anything, but it just takes you there. It’s a very different experience when you have so many similarities. (Participant #6)

Participants began to think of clients in a different way and recognize aspects of their practice they needed to adjust to express an enhanced level of care and understanding.

I think to work in a deliberate manner to convey that feeling of comfort, safety, professionalism, reassurance that they’re going to remember. That there was an individual that was present, that listened, that “got it” when so many others didn’t. That they know someone there’s got their back. Someone’s looking out for them. (Participant #9)

More than ever, the participants saw themselves as being on the same side as their clients. They became more aware of the language they used to describe clients and client situations, especially the use of terms which could be stigmatizing. Participants also became much more conscious of issues of privacy and confidentiality.

One participant described specific changes in approach to clients, since the personal health event.

I think I'm a little bit quicker to ask folks what their understanding is, or what's their understanding about the situation. To be a little bit more careful about coming to a conclusion about how knowledgeable or unknowledgeable they are about a situation, about disease process, about resources, about anything. Of the importance just to really, really begin where they are. (Participant #9)

The experience of being a client helped this social worker to realign with one of the primary directives of social work, to start where the client is. Participants found themselves more tolerant of the range of emotions which clients may experience. For example, the frustration and anger clients express was normalized and social workers were more likely to acknowledge and legitimize this aspect of the client experience. "I am aware that some of the complaints patients and families make about healthcare are truly fact based, so in my work I try to be open to their issues and connect them with the appropriate team members" (Participant #7). Having experienced the frustrations of dealing with the healthcare system, some of the participants found that they did not take it as personally or find it as alarming when clients became angry.

The social workers also prioritized different interventions in their approaches to clients.

I think it also helped for me to create how we're more than just the surface tasky things, that we really need to understand how individuals are impacted when they come into hospital. That we really need to get to that psycho-emotional challenge that they face. And that we need to take that time, not overly, but take that time to understand them. (Participant #6)

The experience of being a client leads toward a greater depth of practice, recognizing that clients will process their experiences in different ways and need the time and support to do so.

Participants expressed more of an inclination to "step out of the chaos", to give clients the attention they need rather than acquiescing to system pressures.



The experience of being a recipient of services further motivated social workers to retain a client focus, rather than a system focus.

I think being a client helped me be a better social worker. It's unfortunate I had to go through the experiences, but I think that if I wasn't a client, I don't think I could see. I think I bring to my practice my personal experiences and I think that keeps me grounded and more open. I don't fall into that mentality, like the way the rest of the group kind of goes. If I see myself doing it, I bring it back. I'm more insightful to my practice. (Participant #5)

All of the participants talked about the ways that they were committed to helping clients to better understand and function within the system, while also making efforts to help the system appreciate the experiences of services recipients. For some of the participants, the experience of receiving health services has contributed to their own sense of power and purpose.

I feel I'm stronger now and I can tackle a lot more things than what I may have done [before the experience]. I just feel there's a "braverness" about me. Courage, I guess. It's just there's a deeper level of compassion for me to really understand where my patients are, where my clients are. Where I can become a stronger advocate and really work for them. (Participant #6)

As a result of their own experiences, participants made greater efforts to educate and challenge team members in the interest of clients.

The social workers also shared the meanings they had taken from their experiences, and saw this as a means of instilling hope for clients.

I usually tell people, you will never be the same, having gone through that. And I'm not the same person I was before [chronic illness] hit. But the changes that come are not always bad. You gain a lot from this. In my case, I got a profound feeling of empathy from people. I started to notice all the small acts of kindness that were going on around me, that I might have just taken for granted before. (Participant #1)

The participants saw their experiences as helping them to connect to what is important to them as social workers, but also to what is important in life. As one participant remarked, "I keep living

and I'm very thankful that I can do that. I'm appreciative of every moment that I have"

(Participant #6).

Although the experience of being a client was often difficult and painful, all of the participants believed they had gained something valuable from the experience.

But I certainly find having been a consumer, a client of the healthcare system, to have been very, very beneficial. While I wouldn't want to do it again! I think it's all in all, professionally it's been a very good thing. Personally, it's been a good thing. And I guess finally, I can say I'm proud to be a part of the social work profession having seen and having been on the receiving end of social work services. (Participant #9)

Becoming a recipient of healthcare offered the social workers opportunities to re-examine their values and beliefs, thereby reconnecting with what was most important to them and renewing their motivation to take actions which were consistent with personal and professional priorities.

## **Conclusion**

For each of the health social workers participating in this study, the experience of being a recipient of healthcare was a source of professional insight and growth. All of the participants identified areas where their practice perspectives had shifted following their client experiences. In particular, they noted greater empathy and compassion for people who require healthcare, including recognizing the extent of psycho-emotional and family systems impacts of health events, as well as the challenges of navigating the health system in the absence of insider knowledge. They were more inclined to believe what clients told them, respect different perspectives, take time with people, and strive to connect on a human level – all of which promotes therapeutic alliance. The participants became increasingly aware of the dynamics of client vulnerability and professional power. They expressed renewed commitments to advocacy or other deliberate actions which could promote agency and instigate system change.

As would be expected from the standpoints of social constructivism and critical theory, social workers who had gained a dual perspective as both healthcare providers and recipients possessed an expanded outlook on the “realities” of the healthcare system than had previously been the case from a single point of view. This is not to say that health social workers and their inter-professional colleagues have not always been concerned with providing a high quality of care. Rather, for these participants, the experience of being a healthcare recipient offered them new insights into what constitutes care quality from a client perspective. Their beliefs about healthcare changed, both in terms of how clients and families experience typical system activities as well as how healthcare providers ought to use their professional power to serve healthcare recipients throughout the care journey.

For many of the participants, the experience of undergoing a health event and receiving healthcare was truly transformative. Practice transformation seemed to be more strongly associated with experiences which had the greatest personal impacts and prompted deeper levels of self-reflection. Although these experiences were at times uncomfortable and unwelcome, the social workers articulated and appreciated the value of the experience and the wisdom gained, both personally and professionally. Being a client helped them to reconnect with what was really important to them as social workers. Given the relentless pressures and conflicting priorities within healthcare systems, engaging in ongoing critical reflexivity is crucial to the enactment of professional values and therefore the advancement of quality, person-centred care.

### **Implications for Practice, Policy, and Research**

From the experience of being healthcare recipients, social workers gained new insights into the challenges and barriers people face when accessing services within the health system.

This contributes knowledge for the profession in terms of existing gaps in service, the usefulness of different approaches, and the need to advocate for service delivery changes. At the same time, it suggests that most social workers and other health professionals may not currently have sufficient awareness of how clients actually experience the health system. This may provide evidence to develop inter-professional education with respect to the client experience, enhanced structures within health organizations to promote client feedback, or policies which require client participation in system-level decision making. When considering measures of healthcare quality, there would be value in assessing how clients and families experience the system psycho-emotionally, beyond more typical quality measure such as service utilization and wait times. Such measures could contribute further rationale for the role of social work in healthcare settings.

As a profession, social workers are already leaders in advocating for person-centred care; however additional opportunities to critically reflect upon their own practice may provide further impetus to take meaningful actions to enhance alliance and promote agency amongst service recipients. The experience of becoming a client naturally prompted critical self-reflection and transformation for these participants. Several of the participants commented on how beneficial it was to discuss their experiences in the research interview itself. It is important to consider how the learnings from such experiences could be enhanced and sustained, or whether there are other ways to promote ongoing critical reflexivity amongst health social workers in the absence of personal healthcare experiences.

Given the value of these transformative experiences to the practice of these participants, efforts to promote such learning are applicable to social work continuing education and research. Through personal client experience, these social workers were prompted to evaluate their own

values and actions. Potentially another avenue for social workers to explore these factors, without direct exposure as healthcare recipients, is the field of ethics. It would be interesting to explore whether robust attention to ethical decision making in practice, which would necessitate reflection upon personal and professional values, weighing competing interests, and making deliberate practice choices, could have similar transformative impacts on practice (Banks, 2008; Mattison, 2000).

Finally, it is not sufficient for social workers to gain enhanced awareness of power and oppression within the healthcare system without the capacity to influence change. Health practice is becoming ever more challenging for social workers, given increasing demands and constraints upon the health system. It is conceivable that increased awareness of the challenges of the client experience, without the ability to create meaningful change, would increase moral distress amongst health social workers. As this study deliberately selected participants who were continuing to work within healthcare, it is unknown whether there may have been health social workers who found their health recipient experiences and/or awareness of personal participation in oppression so disruptive that they could no longer continue to work within the health system. A future area of research could focus on the supports and structures health social workers require to use their professional power to effectively challenge the system in the interests of health care recipients. Inasmuch as clients and families require hope to embark on a personal health journey, healthcare social workers too need hope to sustain the professional voyage.

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## Appendix A

### Certificate of Fraser Health Research Ethics Board Approval

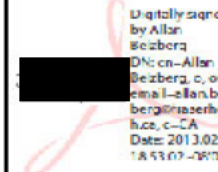
FHREB 2013-017

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**Fraser Health Research Ethics Board**  
FHA, Evaluation and Research Services  
#400, 13450 102<sup>nd</sup> Avenue, Surrey, BC V3T 0H1  
Phone: 604.587.4436 Fax: 604.930.5425

#### CERTIFICATE OF FHREB APPROVALS

<b>Official Notification - FHREB Number (to be used on all future correspondence): FHREB 2013-017</b>				
<b>Principal Investigator:</b> TORHELM, Shannon		<b>Hospital/Facility &amp; Department:</b> Abbotsford Regional Hospital/Social Work		
<b>Institution(s) or Geographical Areas where research will be carried out:</b> Work sites within Fraser Health				
<b>Co-Investigator(s):</b> Dr. Adrienne Chan, Dr. Leah Douglas				
<b>Funding Agencies and/or Corporate Sponsor:</b> unfunded				
<b>Title:</b> Effects On Social Work Practice When Health Social Workers Become Recipients Of Healthcare				
<b>Documents Included in this Approval</b>	<b>Date of Approval</b>	<b>Date of Expiry</b>	<b>Type of Approval</b>	<b>Approval of the FHREB</b>
<ul style="list-style-type: none"><li>• Application for Initial Review, dated 2013 February 4</li><li>• Protocol, 2013 February 3</li><li>• Consent Form, 2013 February 3</li><li>• Interview Questions, 2013 February 3</li><li>• Recruitment Letter, 2013 February 3</li></ul>	2013 February 08	2014 February 8	Initial Approval; Delegated Review	 <p>Digitally signed by Allan Belzberg DN: cn=Allan Belzberg, c=ou, email=allen.belzberg@fraserhealth.ca, c=CA Date: 2013.02.08 18:53:07 -0800</p>
<ul style="list-style-type: none"><li>• Amendment Application Form, 2013 February 25</li><li>• Consent Form, 2013 February 25</li></ul>	2013 February 27	2014 February 08	Amendment Approval; Delegated Review	

#### **CERTIFICATION:**

##### **With respect to clinical trials:**

- The membership of the Fraser Health Research Ethics Board complies with the membership requirements for research ethics boards as defined in Part C Division 5 of the Food and Drug Regulations and the Tri-Council Policy Statement.
- The Fraser Health Research Ethics Board carries out its functions in a manner consistent with Good Clinical Practices.
- The Fraser Health Research Ethics Board has reviewed and approved the clinical trial protocol and the informed consent form for the trial which is to be conducted by a qualified investigator named at the specified clinical trial site. This approval of the documentation listed above and the views of the Fraser Health Research Ethics Board have been documented in writing.

##### **With respect to delegated review:**

A co-chair of the FHREB has reviewed and approved the documentation listed above for the forenamed research study in accordance with the FHREB Policy on "Ethical Conduct of Research and Other Studies Involving Human Subject", the Tri-council Policy Statement: Ethical Conduct for Research Involving Human, and the "International Conference on Harmonisation Guidance E6: Good Clinical Practice E6: Consolidated Guidelines".

##### **With respect to full board review:**


Full FHREB review and approval of the documentation listed above was completed for non-expedited review in accordance with the FHREB Policy on "Ethical Conduct of Research and Other Studies Involving Human Subjects", the Tri-council Policy Statement: Ethical Conduct for Research Involving Human and the "International Conference on Harmonisation Guidance E6: Good Clinical Practice E6: Consolidated Guidelines".

The FHREB approval for this study expires **ONE year from the approval date of this certificate**. Researchers must submit a Request for Annual Renewal for ongoing research studies prior to the expiry date in order to receive annual re-approval.

Appendix B  
Certificate of Human Research Ethics Board Approval, University of the Fraser Valley



**Certificate of Human Research Ethics Board Approval**

Contact Person Shannon Torhjem	Department Social Work	Protocol # 557
Co-investigators Sheri van Lochem - supervisor		
Title of Project Effects On Social Work Practice When Health Social Workers Become Recipients Of Healthcare		
Sponsoring/Funding Agency None		
Institution(s) where research will be carried out University Of The Fraser Valley		
Review Date: 25-Feb-13	Approval Date: 05-Mar-13	Approval Term: 5-Mar-13 - 04-Mar-14
<p>Certification:</p> <p style="text-align: center;"><i>The protocol describing the above-named project has been reviewed by the UFV Human Research Ethics Board and the procedures were found to be in compliance with accepted guidelines for ethical research.</i></p> <div style="text-align: center; margin: 20px 0;">  </div> <p style="text-align: center;">Kathy Keiver, Chair, Human Research Ethics Board</p> <p><i>NOTE: This Certificate of Approval is valid for the above noted term, provided there is no change in the procedures or criteria given.</i></p> <p><i>If the project will go beyond the approval term noted above, an extension of approval must be requested.</i></p>		

## Appendix C

### Invitation to Participate



Social Work  
Abbotsford Regional Hospital  
32900 Marshall Road, Abbotsford, BC V2S 0C2  
Phone: 604.851.4700 Fax: 604.851.4872

#### INVITATION TO PARTICIPATE IN RESEARCH INTERVIEW

##### **Effects on Social Work Practice when Health Social Workers become Recipients of Healthcare**

Dear Potential Participant;

I am currently conducting a study to explore the effects on social work practice after health social workers have a personal experience of receiving health care. This includes how social workers perceive the social work role within the health system and how this experience affects their interactions with clients/families and with the health care team. This study will also examine how social workers' perspectives may change with respect to practice priorities or the influence of power within the health system.

This research is being conducted for a Master of Social Work project at the University of the Fraser Valley. It is hoped that the information learned from this study can be used for the purposes of social work education and social work professional development. This may help to improve the effectiveness of social workers providing care to patients/clients/residents.

You are invited to participate in this study if you meet the following criteria;

1. You are currently working as a social worker in Fraser Health
2. You have had a significant interaction with the healthcare system as a client
  - Significant interaction could include an unexpected health event or the management of an ongoing health condition
  - Client experience includes receiving healthcare yourself, or being a family member of someone receiving healthcare.
3. You are prepared to discuss your experiences of receiving healthcare, taking into consideration how recently this occurred and how personally impactful it was for you
4. You do not have a reporting relationship to me at work

If you agree to take part in this study, there will be one individual interview which will be about one hour long. You will be asked a series of open-ended questions, exploring how your experiences of the health care system as a client have affected your perspective on your own practice as a social worker. The interview will be arranged at a time and location which is convenient for you. It will not take place during your working hours. With your permission, the interview will be audio-recorded.

Your decision whether or not to participate will not be shared with anyone in Fraser Health. Your confidentiality will be respected. Prior to participating in the study, you will be provided with a consent form outlining further details of the study. You are encouraged to ask any questions you have about the study before deciding whether or not to participate. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision. If you do not wish to participate, you do not have to provide any reason for your decision not to participate.



All of the research instruments, sampling, and methodologies are approved by the Research Ethics Boards of both Fraser Health and the University of the Fraser Valley.

If you have any concerns about this research, contact either Dr. Anton Grunfeld or Dr. Allan Belzberg, Fraser Health Research Ethics Board [REB] co-Chairs by calling 604-587-4681. You may also contact Dr. Adrienne Chan at the University of the Fraser Valley by calling 604- 557-4074.

**If you would like to find out more about participating in this study, please contact**

Shannon Torhjem, BA, BSW, RSW  
Social Work Practice Leader / MSW Student  
Abbotsford Regional Hospital  
(604)851-4700 X 646134  
[REDACTED]  
[REDACTED]

## Appendix D Letter of Consent



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### CONSENT FORM

#### Effects on Social Work Practice when Health Social Workers become Recipients of Healthcare

**Principal Investigator:** Shannon Torhjem, BA, BSW, RSW  
[REDACTED]

**Co-Investigator(s):** Dr. Adrienne Chan, BA, MSW, PhD, RSW  
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### INTRODUCTION

My name is Shannon Torhjem and I am a Master of Social Work student at the University of the Fraser Valley. As an educational requirement, I am conducting an exploratory research project to study how the practice of health social workers may be influenced once they have had a significant interaction with the healthcare system as a client (patient or family caregiver).

You are being invited to take part in this research study because you are currently working as a social worker in Fraser Health, and you have also indicated that you have had a significant interaction with the healthcare system as a client. For the purposes of this study, a significant interaction could include an unexpected health event or the management of an ongoing health condition. A client experience includes receiving healthcare yourself, or being a family member of someone receiving healthcare.

### YOUR PARTICIPATION IS VOLUNTARY

Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits and risks.

If you wish to participate, you will be asked to sign this form. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision. If you do not wish to participate, you do not have to provide any reason for your decision not to participate. Your decision whether or not to participate will not be shared with anyone in Fraser Health.

Please take time to read the following information carefully and to discuss any questions before you decide.

## **BACKGROUND**

There is no doubt that personal experiences affect professional responses. Social work practice relies on critical self-reflection and the integration of personal and professional identities. Within a healthcare setting, social workers play a critical role in the lives of people facing health concerns by intervening not only individually, but also at a systems level to reduce health inequities and promote social justice. Having an experience of receiving healthcare may provide health social workers with a different perspective on the issues faced by clients within the health system and could result in different approaches to practice.

## **WHAT IS THE PURPOSE OF THE STUDY?**

The purpose of this study is to explore the effects on social work practice after health social workers have an experience of receiving health care. This includes how social workers perceive the social work role within the health system and how this experience affects their interactions with clients/families and with the health care team. This study will also examine how social workers' perspectives may change with respect to practice priorities or the application of anti-oppressive approaches within the health system.

## **WHO CAN PARTICIPATE IN THE STUDY?**

You can participate in this study if you are currently working as a social worker in Fraser Health. After working as a social worker in health, you have had an experience with the healthcare system as a client (patient or family caregiver) which has been significant for you, and you have been practicing as a social worker since that experience.

## **WHO SHOULD NOT PARTICIPATE IN THE STUDY?**

If your interaction with the health system as a client was very recent or if something about this experience was upsetting for you, you should consider whether you are currently prepared to discuss this topic.

Any Fraser Health social worker with a reporting relationship to the principal investigator will not be invited to participate.

## **WHAT DOES THE STUDY INVOLVE?**

The study involves one individual interview with each participant. The interview will be approximately one hour long. The interview will be scheduled at a time and location which is convenient for you. It will not take place during your working hours. You will be asked a series of open-ended questions, exploring how your experiences with the healthcare system as a client have affected your perspective on your own practice as a social worker. With your permission, the interview will be audio recorded and notes will be taken. If you do not want the interview recorded, only notes will be taken. The purpose of the audio recording &/or note taking is to review the ideas and themes you share and compare the experiences of all the study participants. You will be offered a written summary of your interview and will have an opportunity to correct, clarify or add information if you wish. In total, there will be 10 to 15 people participating in this study.

## **WHAT ARE THE POSSIBLE RISKS OF HARM AND SIDE EFFECTS OF PARTICIPATING?**

The interview will involve discussing your thoughts and feelings about the health care system, both as a healthcare recipient and as a social worker. Depending on your personal experiences, it is possible that you could experience some emotional discomfort from thinking and talking about these experiences.

## **WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?**

There may or may not be direct benefits to you from taking part in this study. You may benefit from the opportunity to reflect upon and share your own experiences.



It is hoped that the information learned from this study can be used for the purposes of social work education and social work professional development. For example, the information may be presented at professional conferences. This may help to improve the effectiveness of social workers providing care to patients/clients/residents.

#### **WHAT HAPPENS IF I DECIDE TO WITHDRAW MY CONSENT TO PARTICIPATE?**

Your participation in this research is entirely voluntary. You may choose not to answer particular questions and you may end the interview at any time. You may also withdraw any data you have already provided. There will be no effect on your employment with Fraser Health.

#### **WHAT HAPPENS IF SOMETHING GOES WRONG?**

By signing this form, you do not give up any of your legal rights. The principal investigator is a social worker and available to discuss any emotional discomfort you may experience while participating. The principal investigator may decide to discontinue the interview, if it is felt that would be in your best interests. If you want, you may access support from a registered counselor via the Employee and Family Assistance Program at no cost (up to 10 visits/calendar year).

#### **AFTER THE STUDY IS FINISHED**

You will be offered the option of receiving a copy of the final report of this project.

#### **WHAT WILL THE STUDY COST ME?**

It is not anticipated that you will incur any personal expenses as a result of participation in this study. You will not be paid for participating.

#### **WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?**

Your confidentiality will be respected. However, research records identifying you may be inspected in the presence of the Investigator or her designate by representatives the University of the Fraser Valley and the Fraser Health Research Ethics Board for the purpose of monitoring the research. The study will be supervised by the Co-Investigators, Dr. Adrienne Chan and Dr. Leah Douglas. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

You will be assigned a unique study number as a participant in this study. Only this number will be used on any research-related information collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a participant in this study will be kept confidential. Information that contains your identity will remain only with the Principal Investigator and/or designate. The list that matches your name to the unique study number that is used on your research-related information will not be removed or released without your consent unless required by law. The data will be kept secure and will be held for five years, and then destroyed.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to insure that your privacy is respected and also give you the right of access to the information about you that has been collected and, if need be, an opportunity to correct any errors in this information. Further details about these laws are available on request.

**WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY DURING MY PARTICIPATION?**

If you have any questions or desire further information about this part of the study before or during participation, you can contact Principal Investigator, Shannon Torhjem at 604-302-7044.

**WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY RIGHTS AS A PARTICIPANT DURING THE STUDY?**

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact either Dr. Anton Grunfeld or Dr. Allan Belzberg, Research Ethics Board [REB] co-Chairs by calling 604-587-4681. You may discuss these rights with the co-chairmen of the Fraser Health REB.

**EFFECTS ON SOCIAL WORK PRACTICE WHEN  
HEALTH SOCIAL WORKERS BECOME RECIPIENTS OF HEALTHCARE**

**Principal Investigator:** Shannon Torhjem, BA, BSW, RSW



**Co-Investigator(s):** Dr. Adrienne Chan, BA, MSW, PhD, RSW  
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Dr. Leah Douglas, BSW, MSW, PhD, RSW  
(604) 504-7441 Local 4292  
leah.douglas@ufv.ca

**PARTICIPANT CONSENT TO PARTICIPATE**

- I have read and understood the participant information and consent form and am consenting to participate in the study "Effects on Social Work Practice when Health Social Workers become Recipients of Healthcare"
- I have had sufficient time to consider the information provided and to ask for advice if necessary.
- I have had the opportunity to ask questions and have had satisfactory responses to my questions.
- I understand that all of the information collected will be kept confidential and that the result will only be used for scientific objectives.
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time without affecting my employment with Fraser Health.
- I understand that I am not waiving any of my legal rights as a result of signing this consent form.
- I understand that there is no guarantee that this study will provide any benefits to me.
- I have read this form and I freely consent to participate in this study.
- I agree that the interview will be audio recorded.
- I have been offered the option of receiving a written summary of my interview, as well as a copy of the final report of this project.
- I have been told that I will receive a dated and signed copy of this form.

**SIGNATURES**

\_\_\_\_\_  
Printed Name of Participant

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Principal Investigator

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Appendix E

### Interview Guide

#### Research Question:

For Social Workers employed in health care, how does having a significant interaction with the health care system as a client (patient or family caregiver) influence their own practice perspective?

#### Background Questions:

1. Level of Social Work training - BSW/MSW
2. Length of time working in Health SW – (years)
3. Employment status (full time, part time, casual)
4. Length of time since client experience occurred/began
5. Gender-
6. Age (range 20- 30; 30 – 40; 40-50; 50-60; 60+)
7. Other self-identified social location/diversity factors (race, language, ability, orientation)

#### Interview Questions:

1. Reflecting on your experience as a client, what have you learned about the health care system that you didn't know before?
2. In the course of your experience of receiving health services, did you ever talk to a social worker?
  - a. If so;
    - i. What was your impression of the social work intervention offered?
    - ii. How did it feel to be on the receiving end of social work services?
  - b. If not;
    - i. Did anyone within the health system talk to you about how you or your family were being affected by the health condition or event?
    - ii. What was your impression of your interactions with these health professionals? (Either talking or not talking about possible effects of the health condition or event).
3. How do you think being a health social worker affected your experience of being a health care recipient?
4. Did this experience influence what you think about the role of social workers in health? If so, how?
5. Did this experience influence how you feel about working within the health system? If so, how?
6. Since having this experience, what recommendations would you share with other clients/families who need to access healthcare?
7. From what you learned (assuming you learned something...) from being a client and the client experience, what would you share with your colleagues that might help them improve practice, or consider other elements of working with clients?
8. What have you taken back to your own practice as a social worker since you've had this client experience?

9. Since having this experience, have you thought about the influences of power/oppression (empowerment/disempowerment) within the health system? If so, what are your reflections? Has anything changed about your perspective since becoming a client?
10. What is your interpretation of Anti-Oppressive practice?
11. Since having this client experience, what are your thoughts about the application of anti-oppressive approaches to health practice?
12. Are there any other comments you would like to make regarding your experiences of being a client and being a social worker?